Great Smokies Diagnostic Lab
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Food Allergy Questionnaire

Patient Name _____ **Date** _____

This questionnaire is designed to help determine whether some of your symptoms are related to delayed food allergy. Please read each question carefully, fill in all the blanks, and circle either yes or no on the left and the appropriate response on the right.

1. What foods do you eat more than once a day? (example: cola, tea, milk, bread, candy)

_____

_____

2. List any foods that make you sick or disagree with you:

_____

_____

Yes *No* **3.** Are you awakened between the hours of 1:00 and 5:00 AM with the following symptoms: headache, dizziness, stomach cramps, bloating, food cravings, or dry cough?

Yes *No* **4.** Does any member of your family have hay fever, asthma, hives, chronic skin condition, migraine headache, dizziness, stomach cramps, bloating, dry cough, or a sinus condition?

Yes *No* **5.** During childhood, did you have any of the following: eczema, hay fever, asthma, or frequent earaches?

Yes *No* **6.** Were you told that you had colic feeding problems as a baby?

Yes *No* **7.** Do you have itching of the skin, palate, or roof of the mouth?

How often does it occur? (Circle one: Daily, weekly, or monthly)

Yes *No* **8.** Do you notice swelling of the ankles, feet, hands, or face on arising in the morning?

Yes *No* **9.** Do you sleep after large meals during the day?

Yes *No* Do you ever feel sleepy 1 to 2 hours after a large meal?

How often does this occur? _____

Yes *No* **10.** Do you ever have a dry cough? (Circle one: Daily, weekly, or monthly)

How many times might you cough in 24 hours? (Circle one: 5 10 20 30 40 50 75 100 >100)

Yes *No* **11.** Do you eat snacks between meals?

List the foods: _____

Yes *No* **12.** Do you have excessive chilling when a sudden change in temperature occurs?

Yes *No* **13.** Do you have severe migraine headaches?

How often? (Circle one: Daily, Weekly, Monthly, Every several months)

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Yes *No* **14.** Do you have sinus headaches?

How often? (Circle one: Daily, Weekly, Monthly, Every several months)

Yes *No* **15.** Do you have headaches in the back of your head?

How often? (Circle one: Daily, Weekly, Monthly, Every several months)

Yes *No* **16.** Do you ever have gas, belching, bloating after meals, or cramps?

How often do you have this? (Circle one: Daily, Weekly, Monthly)

Yes *No* **17.** Have you noticed numbness of the face, arms, or legs at periodic intervals for no apparent cause?

How often? (Circle one: Daily, Weekly, Monthly)

Yes *No* **18.** Do you have drowsiness, headache, or bloating after the ingestion of a cocktail, beer, or wine?

Yes *No* **19.** Are you allergic to penicillin?

Yes *No* **20.** Do you ever have any diarrhea, even mild or intermittent?

How often? (Circle one: Daily, Weekly, Monthly)

Yes *No* **21.** Do you have repeated symptoms on awakening in the morning, such as headache?

List other recurring symptoms: _____

Yes *No* Can you make the symptoms go away by eating or drinking any particular food, such as coffee or cola?

List the foods that help improve the symptoms: _____

Yes *No* **22.** Are there any other reactions or problems that you notice with any other foods?

List these foods: _____

Yes *No* **23.** Do you ever clear your throat?

How often does this occur? (Circle one: Daily, Weekly, Monthly)

How many times per day? (Circle one: 1-2 5 10 20 30 40 50 75 100 >100)

Yes *No* **24.** Do you ever have dizziness with a sense of motion?

Yes *No* Does this occur by spells?

Yes *No* When you move your head?

How long does the average spell last without stopping? (Circle one: 5-10 sec 1-2 min 15-30 min >1 hr)

Yes *No* **25.** Does your weight increase or decrease 4-5 pounds in a 1-week period?

Sourced with permission from:
Dixon, HS. Food Allergy Questionnaire. In: Trevino, RJ, Dixon, HS. Food Allergy, AAOA Monograph Series, New York: Thieme Medical Publishers;1997, p. 40-42. ISBN 0-86577-618-0.